

# Title 22: HEALTH AND WELFARE

## Chapter 401: GENERAL PROVISIONS

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**Maine Revised Statutes**  
**Title 22: HEALTH AND WELFARE**  
**Chapter 401: GENERAL PROVISIONS**

**§1701. PROGRAM OF HEALTH SERVICES**

The department, through its Bureau of Health, is authorized to administer a program to extend and improve its services for promoting the general public health.

The department is authorized to:

**1. Apply for federal aid.** Apply for federal aid under the Public Health Service Act (Public Law No. 410, 78th Congress Second Session as heretofore or hereafter amended);

**2. Cooperate with Federal Government.** Cooperate with the Federal Government through the United States Public Health Service in matters of mutual concern pertaining to general public health, including such methods of administration as are found to be necessary for the efficient operation of the plan for the aid; and

[ 1981, c. 470, Pt. A, §70 (AMD) .]

**3. Reports.** Make such reports in such form and containing such information as the Surgeon General of the United States Public Health Service may require, and comply with such provisions as said Surgeon General may find necessary to assure the correctness and verification of such reports.

The Treasurer of State shall be the appropriate fiscal officer of the State to receive federal grants on account of general public health services as contemplated by Public Health Service Act, as heretofore or hereafter amended, and the State Controller shall authorize expenditures therefrom as approved by the department.

SECTION HISTORY

1981, c. 470, §A70 (AMD).

**§1702. HOSPITAL SURVEYS**

*(REPEALED)*

SECTION HISTORY

1965, c. 231, §1 (RP).

**§1703. ACCEPTANCE OF FEDERAL AND OTHER FUNDS**

The department shall have authority to accept any federal law now in effect or hereafter enacted which makes federal funds available for public health services of all kinds and to meet such federal requirements with respect to the administration of such funds as are required as conditions precedent to receiving federal funds. The department, subject to the approval of the Governor, shall have authority to accept funds from other sources for the same purposes. [1975, c. 771, §215 (AMD) .]

SECTION HISTORY

1965, c. 231, §2 (AMD). 1975, c. 771, §215 (AMD).

**§1704. ADVISORY HOSPITAL COUNCIL**

*(REPEALED)*

## SECTION HISTORY

1965, c. 231, §1 (RP).

**§1705. INDIVIDUALS MAY SELECT OWN PHYSICIAN**

Nothing in this Title shall be construed to empower or authorize the department or its representative to interfere in any manner with the right of any individual to select the physician or mode of treatment of his choice, providing that sanitary laws, rules and regulations are complied with.

**§1706. DISTRIBUTION OF ANTITOXINS IN EMERGENCY**

The department, with the approval of the Governor, may, for the purpose of aiding in national defense in case of war or in any state emergency declared by the Governor under Title 37-B, section 742, procure and distribute inside the State and sell or give away, in its discretion, antitoxins, serums, vaccines, viruses and analogous products applicable to the prevention or cure of disease. [ 2013, c. 462, §2 (AMD) .]

## SECTION HISTORY

1975, c. 771, §216 (AMD). 2013, c. 462, §2 (AMD).

**§1707. RESPONSIBLE RELATIVES; DUTY OF HOSPITALS**

*(REPEALED)*

## SECTION HISTORY

1973, c. 163, (RP).

**§1708. APPROPRIATIONS FOR AID OF PUBLIC AND PRIVATE HOSPITALS AND NURSING HOMES**

**1. Compensation for hospitals.** Such sums of money as may be appropriated by the Legislature in aid of public and private hospitals shall be expended under the direction of the department, and the expense of administration shall be charged to the appropriation of that department for general administration. The department is authorized to compensate hospitals located in the State of New Hampshire within 15 miles from the Maine - New Hampshire state line or hospitals located in the Provinces of Quebec or New Brunswick, Canada, within 5 miles of the international boundary, for cases where the hospital care is for persons resident in the State of Maine and, in the judgment of the commissioner, adequate local hospital facilities are not available. The department may compensate hospitals at such rates as it may establish for hospital care of persons whose resources or the resources of whose responsible relatives are insufficient therefor, except as provided in subsection 2. Bills itemizing the expenses of such hospital care, when approved by the department and audited by the State Controller, shall be paid by the Treasurer of State.

[ 1975, c. 365, §1 (RPR) .]

**2. Compensation for nursing homes.**

[ 1991, c. 528, Pt. E, §18 (AFF); 1991, c. 528, Pt. E, §17 (RP); 1991, c. 528, Pt. RRR, (AFF); 1991, c. 591, Pt. E, §18 (AFF); 1991, c. 591, Pt. E, §17 (RP) .]

**2-A. Base-year revisions.**

[ 1991, c. 528, Pt. E, §20 (AFF); 1991, c. 528, Pt. E, §19 (RP); 1991, c. 528, Pt. RRR, (AFF); 1991, c. 591, Pt. E, §20 (AFF); 1991, c. 591, Pt. E, §19 (RP) .]

**3. Compensation for nursing homes.** A nursing home, as defined under section 1812-A, or any portion of a hospital or institution operated as a nursing home, when the State is liable for payment for care, must be reimbursed at a rate established by the Department of Health and Human Services pursuant to this subsection. The department may not establish a so-called "flat rate." This subsection applies to all funds, including federal funds, paid by any agency of the State to a nursing home for patient care. The department shall establish rules concerning reimbursement that:

A. Take into account the costs of providing care and services in conformity with applicable state and federal laws, rules, regulations and quality and safety standards; [1991, c. 528, Pt. E, §21 (NEW); 1991, c. 528, Pt. E, §22 (AFF); 1991, c. 528, Pt. RRR, (AFF); 1991, c. 591, Pt. E, §21 (NEW); 1991, c. 591, Pt. E, §22 (AFF).]

A-1. [2001, c. 666, Pt. A, §1 (RP); 2001, c. 666, Pt. E, §1 (AFF).]

B. Are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities; [1995, c. 696, Pt. A, §32 (AMD).]

C. Are consistent with federal requirements relative to limits on reimbursement under the federal Social Security Act, Title XIX; [2001, c. 666, Pt. A, §1 (AMD); 2001, c. 666, Pt. E, §1 (AFF).]

D. Ensure that any calculation of an occupancy percentage or other basis for adjusting the rate of reimbursement for nursing facility services to reduce the amount paid in response to a decrease in the number of residents in the facility or the percentage of the facility's occupied beds excludes all beds that the facility has removed from service for all or part of the relevant fiscal period in accordance with section 333. If the excluded beds are converted to residential care beds or another program for which the department provides reimbursement, nothing in this paragraph precludes the department from including those beds for purposes of any occupancy standard applicable to the residential care or other program pursuant to duly adopted rules of the department; [2013, c. 594, §1 (AMD).]

E. Contain an annual inflation adjustment that:

(1) Recognizes regional variations in labor costs and the rates of increase in labor costs determined pursuant to the principles of reimbursement and establishes at least 4 regions for purposes of annual inflation adjustments; and

(2) Uses the applicable regional inflation factor as established by a national economic research organization selected by the department to adjust costs other than labor costs or fixed costs; and [2013, c. 594, §1 (AMD).]

F. Establish a nursing facility's base year every 2 years and increase the rate of reimbursement beginning July 1, 2014 and every year thereafter. [2013, c. 594, §1 (NEW).]

Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[ 2013, c. 594, §1 (AMD) .]

#### **4. Medicaid savings.**

[ 2011, c. 655, Pt. T, §1 (RP) .]

#### **SECTION HISTORY**

1975, c. 293, §4 (AMD). 1975, c. 365, §1 (RPR). 1989, c. 567, (AMD). 1989, c. 886, §1 (AMD). 1991, c. 528, §§E17,19,21 (AMD). 1991, c. 528, §§E18,20,22, RRR (AFF). 1991, c. 591, §§E17,19,21 (AMD). 1991, c. 591, §§E18,20,22 (AFF). 1991, c. 622, §M8 (AMD). 1991, c. 622, §M9 (AFF). 1993, c. 410, §YY1 (AMD). 1995, c. 696, §§A32,33 (AMD). RR 2001, c. 2, §A33 (COR). 2001, c. 666, §A1 (AMD). 2001, c. 666, §E1 (AFF). 2003, c. 689, §B6 (REV). 2011, c. 655, Pt. T, §1 (AMD). 2013, c. 594, §1 (AMD).

## **§1709. STATE-WIDE PLAN; ADVISORY COUNCIL; DUTIES** **(REPEALED)**

### SECTION HISTORY

1965, c. 231, §3 (NEW). 2003, c. 469, §B4 (RP).

## **§1710. DEFERRED REVENUE PAYMENTS**

The Department of Health and Human Services may make a payment to each general hospital in the State which is certified for participation in the Medical Assistance Program under Title 19 of the Social Security Act, not to exceed the average amount paid to that hospital by the department during a 30-day period in the next preceding fiscal year. Such payment shall constitute a deferred revenue obligation for the hospital. Any unliquidated balance of such obligation shall be repaid to the department upon demand. [1975, c. 293, §4 (AMD); 2003, c. 689, Pt. B, §6 (REV).]

### SECTION HISTORY

1973, c. 175, (NEW). 1975, c. 293, §4 (AMD). 2003, c. 689, §B6 (REV).

## **§1711. PATIENT ACCESS TO HOSPITAL MEDICAL RECORDS**

If a patient of an institution licensed as a hospital by the State, after discharge from such institution, makes written request for copies of the patient's medical records, the copies must, if available, be made available to the patient within a reasonable time unless, in the opinion of the hospital, it would be detrimental to the health of the patient to obtain the records. If the hospital is of the opinion that release of the records to the patient would be detrimental to the health of the patient, the hospital shall advise the patient that copies of the records will be made available to the patient's authorized representative upon presentation of a proper authorization signed by the patient. The hospital may exclude from the copies of medical records released any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. [1997, c. 793, Pt. A, §1 (AMD); 1997, c. 793, Pt. A, §10 (AFF).]

If an authorized representative for a patient requests, in writing, that a hospital provide the authorized representative with a copy of the patient's medical records and presents a proper authorization from the patient for the release of the information, copies must be provided to the authorized representative within a reasonable time. [1997, c. 793, Pt. A, §1 (AMD); 1997, c. 793, Pt. A, §10 (AFF).]

A written request or authorization for release of medical records under this section satisfies the requirements of section 1711-C, subsection 3. [1997, c. 793, Pt. A, §1 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a hospital health care information that corrects or clarifies the patient's treatment record, which must be retained with the medical record by the hospital. If the hospital adds to the medical record a statement in response to the submitted correction or clarification, the hospital shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem. [1999, c. 512, Pt. A, §1 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

Reasonable costs incurred by the hospital in making and providing paper copies of medical records and additions to medical records may be assessed as charges to the requesting person and the hospital may require payment prior to responding to the request. The charge for paper copies of records may not exceed \$5 for the first page and 45¢ for each additional page, up to a maximum of \$250 for the entire medical record. [2013, c. 158, §1 (AMD).]

If a medical record exists in a digital or electronic format, the hospital shall provide an electronic copy of the medical record if an electronic copy is requested and it is reasonably possible to provide it. The hospital may assess as charges reasonable actual costs of staff time to create or copy the medical record and the costs of necessary supplies and postage. Actual costs may not include a retrieval fee or the costs of new technology, maintenance of the electronic record system, data access or storage infrastructure. Charges assessed under this paragraph may not exceed \$150. [2013, c. 158, §2 (NEW).]

Release of a patient's medical records to a person other than the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem is governed by section 1711-C. [1999, c. 512, Pt. A, §2 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

#### SECTION HISTORY

1977, c. 122, (NEW). 1997, c. 793, Pt. A, §1 (AMD). 1997, c. 793, Pt. A, §10 (AFF). 1999, c. 3, §§3, 5 (AFF). 1999, c. 512, Pt. A, §§1, 2 (AMD). 1999, c. 512, Pt. A, §6 (AFF). 1999, c. 790, Pt. A, §§58, 60 (AFF). 2003, c. 418, §1 (AMD). 2013, c. 32, §1 (AMD). 2013, c. 158, §§1, 2 (AMD).

### §1711-A. FEES CHARGED FOR RECORDS

Whenever a health care practitioner defined in section 1711-B furnishes in paper form requested copies of a patient's treatment record or a medical report or an addition to a treatment record or medical report to the patient or the patient's authorized representative, the charge for the copies or the report may not exceed the reasonable costs incurred by the health care practitioner in making and providing the copies or the report. The charge for the copies or the report may not exceed \$5 for the first page and 45¢ for each additional page, up to a maximum of \$250 for the entire treatment record or medical report. [2013, c. 158, §3 (AMD).]

If a treatment record or medical report exists in a digital or electronic format, the health care practitioner shall provide an electronic copy of the treatment record or medical report if an electronic copy is requested and it is reasonably possible to provide it. The health care practitioner may assess as charges reasonable actual costs of staff time to create or copy the treatment record or medical report and the costs of necessary supplies and postage. Actual costs may not include a retrieval fee or the costs of new technology, maintenance of the electronic record system, data access or storage infrastructure. Charges assessed under this paragraph may not exceed \$150. [2013, c. 158, §3 (NEW).]

#### SECTION HISTORY

1989, c. 666, (NEW). 1991, c. 142, §1 (AMD). 1997, c. 793, §A2 (AMD). 1997, c. 793, §A10 (AFF). 1999, c. 3, §§3,5 (AFF). 1999, c. 512, §A6 (AFF). 2003, c. 418, §2 (AMD). 2013, c. 32, §2 (AMD). 2013, c. 158, §3 (AMD).

### §1711-B. PATIENT ACCESS TO TREATMENT RECORDS; HEALTH CARE PRACTITIONERS

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Health care practitioner" has the same meaning as in section 1711-C, subsection 1, paragraph F. [1997, c. 793, Pt. A, §3 (AMD); 1997, c. 793, Pt. A, §10 (AFF).]

B. "Treatment records" means all records relating to a patient's diagnosis, treatment and care, including x rays, performed by a health care practitioner. [1997, c. 793, Pt. A, §3 (AMD); 1997, c. 793, Pt. A, §10 (AFF).]

[ 1997, c. 793, Pt. A, §3 (AMD); 1997, c. 793, Pt. A, §10 (AFF); 1999, c. 512, Pt. A, §6 (AFF) .]

**2. Access.** Upon written authorization executed in accordance with section 1711-C, subsection 3, a health care practitioner shall release copies of all treatment records of a patient or a narrative containing all relevant information in the treatment records to the patient. The health care practitioner may exclude from the copies of treatment records released any personal notes that are not directly related to the patient's past or future treatment and any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. The copies or narrative must be released to the designated person within a reasonable time.

If the practitioner believes that release of the records to the patient is detrimental to the health of the patient, the practitioner shall advise the patient that copies of the treatment records or a narrative containing all relevant information in the treatment records will be made available to the patient's authorized representative upon presentation of a written authorization signed by the patient. The copies or narrative must be released to the authorized representative within a reasonable time.

Except as provided in subsection 3, release of a patient's treatment records to a person other than the patient is governed by section 1711-C.

[ 1997, c. 793, Pt. A, §4 (AMD); 1997, c. 793, Pt. A, §10 (AFF) .]

**3. Person receiving the records.** Except as otherwise provided in this section, the copies or narrative specified in subsection 2 must be released to:

A. The person who is the subject of the treatment record, if that person is 18 years of age or older and mentally competent; [1991, c. 142, §2 (NEW).]

B. The parent, guardian ad litem or legal guardian of the person who is the subject of the record if the person is a minor, or the legal guardian if the person who is the subject of the record is mentally incompetent; [1997, c. 793, Pt. A, §5 (AMD); 1997, c. 793, Pt. A, §10 (AFF).]

C. The designee of a durable health care power of attorney executed by the person who is the subject of the record, at such time as the power of attorney is in effect; or [1997, c. 793, Pt. A, §5 (AMD); 1997, c. 793, Pt. A, §10 (AFF).]

D. The agent, guardian or surrogate pursuant to the Uniform Health-care Decisions Act. [1997, c. 793, Pt. A, §6 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

[ 1997, c. 793, Pt. A, §§5, 6 (AMD); 1997, c. 793, Pt. A, §10 (AFF) .]

**3-A. Corrections and clarifications of treatment records.** A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a health care practitioner health care information that corrects or clarifies the patient's treatment record, which must be retained with the treatment record by the health care practitioner. If the health care practitioner adds to the treatment record a statement in response to the submitted correction or clarification, the health care practitioner shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem.

[ 1999, c. 512, Pt. A, §3 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]



**4. Minors.** This section does not affect the right of minors to have their treatment records treated confidentially pursuant to the provisions of, chapter 260.

[ 1995, c. 694, Pt. D, §28 (AMD); 1995, c. 694, Pt. E, §2 (AFF) .]

**5. HIV test.** Release of information regarding the HIV infection status of a patient is governed by Title 5, section 19203-D.

[ 1999, c. 512, Pt. A, §4 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**6. Hospital records.** Release of treatment records in a hospital is governed by the provisions of section 1711.

[ 1993, c. 2, §11 (COR) .]

**7. Retention of records.** This section does not alter the existing law or ethical obligations of a health care practitioner with respect to retaining treatment records.

[ 1991, c. 142, §2 (NEW) .]

**8. Violation.** A person who willfully violates this section commits a civil violation for which a forfeiture of not more than \$25 may be adjudged. Each day that the treatment records or narrative is not released after the reasonable time specified in subsection 2 constitutes a separate violation, up to a maximum forfeiture of \$100.

[ 1991, c. 142, §2 (NEW) .]

#### SECTION HISTORY

1991, c. 142, §2 (NEW). RR 1993, c. 2, §11 (COR). 1995, c. 694, Pt. D, §28 (AMD). 1995, c. 694, Pt. E, §2 (AFF). 1997, c. 793, Pt. A, §§3-7 (AMD). 1997, c. 793, Pt. A, §10 (AFF). 1997, c. 793, Pt. B, §5 (AMD). 1997, c. 793, Pt. B, §6 (AFF). 1999, c. 3, §§3-5 (AFF). 1999, c. 512, Pt. A, §§3, 4 (AMD). 1999, c. 512, Pt. A, §6 (AFF). 1999, c. 512, Pt. B, §5 (AFF). 1999, c. 790, Pt. A, §§58, 60 (AFF).

## §1711-C. CONFIDENTIALITY OF HEALTH CARE INFORMATION

*(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)*

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Authorized representative of an individual" or "authorized representative" means an individual's legal guardian; agent pursuant to Title 18-A, section 5-802; agent pursuant to Title 18-A, Article 5, Part 9; or other authorized representative or, after death, that person's personal representative or a person identified in subsection 3-B. For a minor who has not consented to health care treatment in accordance with the provisions of state law, "authorized representative" means the minor's parent, legal guardian or guardian ad litem. [2009, c. 292, §3 (AMD); 2009, c. 292, §6 (AFF) .]

A-1. "Authorization to disclose" means authorization to disclose health care information in accordance with subsection 3, 3-A or 3-B. [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF) .]

B. "Disclosure" means the release, transfer of or provision of access to health care information in any manner obtained as a result of a professional health care relationship between the individual and the health care practitioner or facility to a person or entity other than the individual. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. "Health care" means preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, treatment, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that affects an individual's physical, mental or behavioral condition, including individual cells or their components or genetic information, or the structure or function of the human body or any part of the human body. Health care includes prescribing, dispensing or furnishing to an individual drugs, biologicals, medical devices or health care equipment and supplies; providing hospice services to an individual; and the banking of blood, sperm, organs or any other tissue. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. "Health care facility" or "facility" means a facility, institution or entity licensed pursuant to this Title that offers health care to persons in this State, including a home health care provider, hospice program and a pharmacy licensed pursuant to Title 32. For the purposes of this section, "health care facility" does not include a state mental health institute, the Elizabeth Levinson Center, the Aroostook Residential Center or Freeport Towne Square. [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

E. "Health care information" means information that directly identifies the individual and that relates to an individual's physical, mental or behavioral condition, personal or family medical history or medical treatment or the health care provided to that individual. "Health care information" does not include information that protects the anonymity of the individual by means of encryption or encoding of individual identifiers or information pertaining to or derived from federally sponsored, authorized or regulated research governed by 21 Code of Federal Regulations, Parts 50 and 56 and 45 Code of Federal Regulations, Part 46, to the extent that such information is used in a manner that protects the identification of individuals. The Board of Directors of the Maine Health Data Organization shall adopt rules to define health care information that directly identifies an individual. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

"Health care information" does not include information that is created or received by a member of the clergy or other person using spiritual means alone for healing as provided in Title 32, sections 2103 and 3270. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F. "Health care practitioner" means a person licensed by this State to provide or otherwise lawfully providing health care or a partnership or corporation made up of those persons or an officer, employee, agent or contractor of that person acting in the course and scope of employment, agency or contract related to or supportive of the provision of health care to individuals. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

G. "Individual" means a natural person who is the subject of the health care information under consideration and, in the context of disclosure of health care information, includes the individual's authorized representative. [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

H. "Third party" or "3rd party" means a person other than the individual to whom the health care information relates. [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

[ 2009, c. 292, §3 (AMD); 2009, c. 292, §6 (AFF) .]

**2. Confidentiality of health information; disclosure.** An individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility except as provided in subsection 3, 3-A, 3-B, 6 or 11. Nothing in this section prohibits a health care practitioner or health care facility from adhering to applicable ethical or professional standards provided that these standards do not decrease the protection of confidentiality granted by this section.

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**3. Written authorization to disclose.** A health care practitioner or facility may disclose health care information pursuant to a written authorization signed by an individual for the specific purpose stated in the authorization. A written authorization to disclose health care information must be retained with the individual's health care information. A written authorization to disclose is valid whether it is in an original, facsimile or electronic form. A written authorization to disclose must contain the following elements:

A. The name and signature of the individual and the date of signature. If the authorization is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature; [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

B. The types of persons authorized to disclose health care information and the nature of the health care information to be disclosed; [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

C. The identity or description of the 3rd party to whom the information is to be disclosed; [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

D. The specific purpose or purposes of the disclosure and whether any subsequent disclosures may be made pursuant to the same authorization. An authorization to disclose health care information related to substance abuse treatment or care subject to the requirements of 42 United States Code, Section 290dd-2 (Supplement 1998) is governed by the provisions of that law; [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

E. The duration of the authorization; [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

F. A statement that the individual may refuse authorization to disclose all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences; [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

G. A statement that the authorization may be revoked at any time by the individual by executing a written revocation, subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation, instructions on how to revoke an authorization and a statement that revocation may be the basis for denial of health benefits or other insurance coverage or benefits; and [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

H. A statement that the individual is entitled to a copy of the authorization form. [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**3-A. Oral authorization to disclose.** When it is not practical to obtain written authorization under subsection 3 from an individual or person acting pursuant to subsection 3-B or when a person chooses to give oral authorization to disclose, a health care practitioner or facility may disclose health care information pursuant to oral authorization. A health care practitioner or facility shall record with the individual's health

care information receipt of oral authorization to disclose, including the name of the authorizing person, the date, the information and purposes for which disclosure is authorized and the identity or description of the 3rd party to whom the information is to be disclosed.

[ 1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**3-B. Authorization to disclose provided by a 3rd party.** When an individual or an authorized representative is unable to provide authorization to disclose under subsection 3 or 3-A, a health care practitioner or facility may disclose health care information pursuant to authorization to disclose that meets the requirements of subsection 3 or 3-A given by a 3rd party listed in this subsection. A health care practitioner or facility may determine not to obtain authorization from a person listed in this subsection when the practitioner or facility determines it would not be in the best interest of the individual to do so. In making this decision, the health care practitioner or facility shall respect the safety of the individual and shall consider any indicators, suspicion or substantiation of abuse. Persons who may authorize disclosure under this subsection include:

A. The spouse of the individual; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. A parent of the individual; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. An adult who is a child, grandchild or sibling of the individual; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. An adult who is an aunt, uncle, niece or nephew of the individual, related by blood or adoption; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

E. An adult related to the individual, by blood or adoption, who is familiar with the individual's personal values; and [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F. An adult who has exhibited special concern for the individual and who is familiar with the individual's personal values. [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[ 1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**4. Duration of authorization to disclose.** An authorization to disclose may not extend longer than 30 months, except that the duration of an authorization for the purposes of insurance coverage under Title 24, 24-A or 39-A is governed by the provisions of Title 24, 24-A or 39-A, respectively.

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**5. Revocation of authorization to disclose.** A person who may authorize disclosure may revoke authorization to disclose at any time, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation. A written revocation of authorization must be signed and dated. If the revocation is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date

of signature. A health care practitioner or facility shall record receipt of oral revocation of authorization, including the name of the person revoking authorization and the date. A revocation of authorization must be retained with the authorization and the individual's health care information.

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**6. Disclosure without authorization to disclose.** A health care practitioner or facility may disclose, or when required by law must disclose, health care information without authorization to disclose under the circumstances stated in this subsection or as provided in subsection 11. Disclosure may be made without authorization as follows:

A. To another health care practitioner or facility for diagnosis, treatment or care of individuals or to complete the responsibilities of a health care practitioner or facility that provided diagnosis, treatment or care of individuals, as provided in this paragraph.

(1) For a disclosure within the office, practice or organizational affiliate of the health care practitioner or facility, no authorization is required.

(2) For a disclosure outside of the office, practice or organizational affiliate of the health care practitioner or facility, authorization is not required, except that in nonemergency circumstances authorization is required for health care information derived from mental health services provided by:

(a) A clinical nurse specialist licensed under the provisions of Title 32, chapter 31;

(b) A psychologist licensed under the provisions of Title 32, chapter 56;

(c) A social worker licensed under the provisions of Title 32, chapter 83;

(d) A counseling professional licensed under the provisions of Title 32, chapter 119; or

(e) A physician specializing in psychiatry licensed under the provisions of Title 32, chapter 36 or 48.

This subparagraph does not prohibit the disclosure of health care information between a licensed pharmacist and a health care practitioner or facility providing mental health services for the purpose of dispensing medication to an individual.

This subparagraph does not prohibit the disclosure without authorization of health care information covered under this section to a state-designated statewide health information exchange that satisfies the requirement in subsection 18, paragraph C of providing a general opt-out provision to an individual at all times and that provides and maintains an individual protection mechanism by which an individual may choose to opt in to allow the state-designated statewide health information exchange to disclose that individual's health care information covered under Title 34-B, section 1207.

This subparagraph does not prohibit the disclosure without authorization of health care information covered under this paragraph to a health care practitioner or health care facility, or to a payor or person engaged in payment for health care, for purposes of care management or coordination of care. Disclosure of psychotherapy notes is governed by 45 Code of Federal Regulations, Section 164.508(a)(2). A person who has made a disclosure under this subparagraph shall make a reasonable effort to notify the individual or the authorized representative of the individual of the disclosure; [ 2013, c. 326, §1 (AMD) .]

B. To an agent, employee, independent contractor or successor in interest of the health care practitioner or facility including a state-designated statewide health information exchange that makes health care information available electronically to health care practitioners and facilities or to a member of a quality assurance, utilization review or peer review team to the extent necessary to carry out the usual and customary activities relating to the delivery of health care and for the practitioner's or facility's lawful purposes in diagnosing, treating or caring for individuals, including billing and collection, risk

management, quality assurance, utilization review and peer review. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [2011, c. 347, §7 (AMD).]

C. To a family or household member unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. To appropriate persons when a health care practitioner or facility that is providing or has provided diagnosis, treatment or care to the individual in good faith believes that disclosure is made to avert a serious threat to health or safety and meets the conditions, as applicable, described in 45 Code of Federal Regulations, Section 164.512(j) (2012). A disclosure pursuant to this paragraph must protect the confidentiality of the health care information consistent with sound professional judgment; [2013, c. 289, §1 (AMD).]

E. To federal, state or local governmental entities in order to protect the public health and welfare when reporting is required or authorized by law, to report a suspected crime against the health care practitioner or facility or to report information that the health care facility's officials or health care practitioner in good faith believes constitutes evidence of criminal conduct that occurred on the premises of the health care facility or health care practitioner; [2011, c. 572, §1 (AMD).]

E-1. To federal, state or local governmental entities if the health care practitioner or facility that is providing diagnosis, treatment or care to an individual has determined in the exercise of sound professional judgment that the following requirements, as applicable, are satisfied:

(1) With regard to a disclosure for public health activities, for law enforcement purposes or that pertains to victims of abuse, neglect or domestic violence, the provisions of 45 Code of Federal Regulations, Section 164.512(b), (c) or (f) (2012) must be met; and

(2) With regard to a disclosure that pertains to a victim of domestic violence or a victim of sexual assault, the provisions of 45 Code of Federal Regulations, Section 164.512(c)(1)(iii)(A) (2012) and Section 164.512(c)(1)(iii)(B) (2012) must be met. [2013, c. 289, §2 (NEW).]

F. [1999, c. 512, Pt. A, §7 (AFF); 1999, c. 512, Pt. A, §5 (RP); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-1. As directed by order of a court or as authorized or required by statute; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-2. To a governmental entity pursuant to a lawful subpoena requesting health care information to which the governmental entity is entitled according to statute or rules of court; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-3. (TEXT EFFECTIVE ON CONTINGENCY; See PL 2013, c. 528, §12) To the Maine Health Data Organization as required by and for use in accordance with chapter 1683. Health care information, including protected health information, as defined in 45 Code of Federal Regulations, Section 160.103 (2013), submitted to the Maine Health Data Organization must be protected by means of encryption; [2013, c. 528, §1 (NEW); 2013, c. 528, §12 (AFF).]

G. To a person when necessary to conduct scientific research approved by an institutional review board or by the board of a nonprofit health research organization or when necessary for a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. A person conducting research or a clinical trial may not identify any individual patient in any report arising from the research or clinical trial. For the purposes of this paragraph, "institutional review board" means any board, committee or other group formally designated by a health care facility and authorized under federal law to review, approve or conduct periodic review of research programs. Health care information disclosed pursuant to this paragraph that identifies an individual must be returned to the health care practitioner or facility from which it was obtained or must be destroyed when it is no longer required for the research

or clinical trial. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

H. To a person engaged in the assessment, evaluation or investigation of the provision of or payment for health care or the practices of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to statutory or professional standards or requirements. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

I. To a person engaged in the regulation, accreditation, licensure or certification of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to standards or requirements for regulation, accreditation, licensure or certification; [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

J. To a person engaged in the review of the provision of health care by a health care practitioner or facility or payment for such health care under Title 24, 24-A or 39-A or under a public program for the payment of health care or professional liability insurance for a health care practitioner or facility or to an agent, employee or contractor of such a person; [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

K. To attorneys for the health care practitioner or facility that is disclosing the health care information or to a person as required in the context of legal proceedings or in disclosure to a court or governmental entity, as determined by the practitioner or facility to be required for the practitioner's or facility's own legal representation; [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

L. To a person outside the office of the health care practitioner or facility engaged in payment activities, including but not limited to submission to payors for the purposes of billing, payment, claims management, medical data processing, determination of coverage or adjudication of health benefit or subrogation claims, review of health care services with respect to coverage or justification of charges or other administrative services. Payment activities also include but are not limited to:

- (1) Activities necessary to determine responsibility for coverage;
- (2) Activities undertaken to obtain payment for health care provided to an individual; and
- (3) Quality assessment and utilization review activities, including precertification and preauthorization of services and operations or services audits relating to diagnosis, treatment or care rendered to individuals by the health care practitioner or facility and covered by a health plan or other payor; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

M. To schools, educational institutions, youth camps licensed under section 2495, correctional facilities, health care practitioners and facilities, providers of emergency services or a branch of federal or state military forces, information regarding immunization of an individual; [2009, c. 211, Pt. B, §17 (AMD).]

N. To a person when disclosure is needed to set or confirm the date and time of an appointment or test or to make arrangements for the individual to receive those services; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

O. To a person when disclosure is needed to obtain or convey information about prescription medication or supplies or to provide medication or supplies under a prescription; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

P. To a person representing emergency services, health care and relief agencies, corrections facilities or a branch of federal or state military forces, of brief confirmation of general health status; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

Q. To a member of the clergy, of information about the presence of an individual in a health care facility, including the person's room number, place of residence and religious affiliation unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

R. To a member of the media who asks a health care facility about an individual by name, of brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; and [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

S. To a member of the public who asks a health care facility about an individual by name, of the room number of the individual and brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B. [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[ 2013, c. 289, §§1, 2 (AMD); 2013, c. 326, §1 (AMD); 2013, c. 528, §1 (AMD); 2013, c. 528, §12 (AFF) .]

**7. Confidentiality policies.** A health care practitioner, facility or state-designated statewide health information exchange shall develop and implement policies, standards and procedures to protect the confidentiality, security and integrity of health care information to ensure that information is not negligently, inappropriately or unlawfully disclosed. The policies of health care facilities must provide that an individual being admitted for inpatient care be given notice of the right of the individual to control the disclosure of health care information. The policies must provide that routine admission forms include clear written notice of the individual's ability to direct that that individual's name be removed from the directory listing of persons cared for at the facility and notice that removal may result in the inability of the facility to direct visitors and telephone calls to the individual.

[ 2011, c. 373, §1 (AMD) .]

**8. Prohibited disclosure.** A health care practitioner, facility or state-designated statewide health information exchange may not disclose health care information for the purpose of marketing or sales without written or oral authorization for the disclosure.

[ 2011, c. 373, §2 (AMD) .]

**9. Disclosures of corrections or clarifications to health care information.** A health care practitioner or facility shall provide to a 3rd party a copy of an addition submitted by an individual to the individual's health care information if:

A. The health care practitioner or facility provided a copy of the original health care record to the 3rd party on or after February 1, 2000; [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. The correction or clarification was submitted by the individual pursuant to section 1711 or 1711-B and relates to diagnosis, treatment or care; [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. The individual requests that a copy be sent to the 3rd party and provides an authorization that meets the requirements of subsection 3, 3-A or 3-B; and [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]



D. If requested by the health care practitioner or facility, the individual pays to the health care practitioner or facility all reasonable costs requested by that practitioner or facility. [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**10. Requirements for disclosures.** Except as otherwise provided by law, disclosures of health care information pursuant to this section are subject to the professional judgment of the health care practitioner and to the following requirements.

A. A health care practitioner or facility that discloses health care information pursuant to subsection 3, 3-A or 3-B may not disclose information in excess of the information requested in the authorization. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. A health care practitioner or facility that discloses health care information pursuant to subsections 3, 3-A, 3-B or 6 may not disclose information in excess of the information reasonably required for the purpose for which it is disclosed. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. If a health care practitioner or facility believes that release of health care information to the individual would be detrimental to the health of the individual, the health care practitioner or facility shall advise the individual and make copies of the records available to the individual's authorized representative upon receipt of a written authorization. [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF).]

D. If a health care practitioner or facility discloses partial or incomplete health care information, as compared to the request or directive to disclose under subsection 3, 3-A, 3-B or 6, the disclosure must expressly indicate that the information disclosed is partial or incomplete. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**11. Health care information subject to other laws, rules and regulations.** Health care information that is subject to the provisions of 42 United States Code, Section 290dd-2 (Supplement 1998); chapters 710-B and 711; Title 5, section 200-E; Title 5, chapter 501; Title 24 or 24-A; Title 34-B, section 1207; Title 39-A; or other provisions of state or federal law, rule or regulation is governed solely by those provisions.

[ 2009, c. 387, §2 (AMD) .]

**12. Minors.** If a minor has consented to health care in accordance with the laws of this State, authorization to disclose health care information pursuant to this section must be given by the minor unless otherwise provided by law.

[ 1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF) .]

**13. Enforcement.** This section may be enforced within 2 years of the date a disclosure in violation of this section was or should reasonably have been discovered.

A. When the Attorney General has reason to believe that a person has intentionally violated a provision of this section, the Attorney General may bring an action to enjoin unlawful disclosure of health care information. [1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF) .]

B. An individual who is aggrieved by conduct in violation of this section may bring a civil action against a person who has intentionally unlawfully disclosed health care information in the Superior Court in the county in which the individual resides or the disclosure occurred. The action may seek to enjoin unlawful disclosure and may seek costs and a forfeiture or penalty under paragraph C. An applicant for injunctive relief under this paragraph may not be required to give security as a condition of the issuance of the injunction. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. A person who intentionally violates this section is subject to a civil penalty not to exceed \$5,000, payable to the State, plus costs. If a court finds that intentional violations of this section have occurred after due notice of the violating conduct with sufficient frequency to constitute a general business practice, the person is subject to a civil penalty not to exceed \$10,000 for health care practitioners and \$50,000 for health care facilities, payable to the State. A civil penalty under this subsection is recoverable in a civil action. [1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. Nothing in this section may be construed to prohibit a person aggrieved by conduct in violation of this section from pursuing all available common law remedies, including but not limited to an action based on negligence. [1999, c. 512, Pt. A, §5 (NEW); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**14. Waiver prohibited.** Any agreement to waive the provisions of this section is against public policy and void.

[ 1997, c. 793, Pt. A, §8 (NEW); 1997, c. 793, Pt. A, §10 (AFF) .]

**15. Immunity.** A cause of action in the nature of defamation, invasion of privacy or negligence does not arise against any person for disclosing health care information in accordance with this section. This section provides no immunity for disclosing information with malice or willful intent to injure any person.

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

**16. Application.** This section applies to all requests, directives and authorizations to disclose health care information executed on or after February 1, 2000. An authorization to disclose health care information executed prior to February 1, 2000 that does not meet the standards of this section is deemed to comply with the requirements of this section until the next health care encounter between the individual and the health care practitioner or facility.

[ 1999, c. 512, Pt. A, §5 (AMD); 1999, c. 512, Pt. A, §7 (AFF); 1999, c. 790, Pt. A, §§58, 60 (AFF) .]

#### **17. Repeal.**

[ 2001, c. 346, §1 (RP) .]

**18. Participation in a state-designated statewide health information exchange.** The following provisions apply to participation in a state-designated statewide health information exchange.

A. A health care practitioner may not deny a patient health care treatment and a health insurer may not deny a patient a health insurance benefit based solely on the provider's or patient's decision not to participate in a state-designated statewide health information exchange. Except when otherwise

required by federal law, a payor of health care benefits may not require participation in a state-designated statewide health information exchange as a condition of participating in the payor's provider network. [2011, c. 691, Pt. A, §20 (RPR).]

B. Recovery for professional negligence is not allowed against any health care practitioner or health care facility on the grounds of a health care practitioner's or a health care facility's nonparticipation in a state-designated statewide health information exchange arising out of or in connection with the provision of or failure to provide health care services. In any civil action for professional negligence or in any proceeding related to such a civil action or in any arbitration, proof of a health care practitioner's, a health care facility's or a patient's participation or nonparticipation in a state-designated statewide health information exchange is inadmissible as evidence of liability or nonliability arising out of or in connection with the provision of or failure to provide health care services. This paragraph does not prohibit recovery or the admission of evidence of reliance on information in a state-designated statewide electronic health information exchange when there was participation by both the patient and the patient's health care practitioner. [2011, c. 691, Pt. A, §20 (RPR).]

C. A state-designated statewide health information exchange to which health care information is disclosed under this section shall provide an individual protection mechanism by which an individual may opt out from participation to prohibit the state-designated statewide health information exchange from disclosing the individual's health care information to a health care practitioner or health care facility. [2011, c. 691, Pt. A, §20 (RPR).]

D. At point of initial contact, a health care practitioner, health care facility or other entity participating in a state-designated statewide health information exchange shall provide to each patient, on a separate form, at minimum:

- (1) Information about the state-designated statewide health information exchange, including a description of benefits and risks of participation in the state-designated statewide health information exchange;
- (2) A description of how and where to obtain more information about or contact the state-designated statewide health information exchange;
- (3) An opportunity for the patient to decline participation in the state-designated statewide health information exchange; and
- (4) A declaration that a health care practitioner, health care facility or other entity may not deny a patient health care treatment based solely on the provider's or patient's decision not to participate in a state-designated statewide health information exchange.

The state-designated statewide health information exchange shall develop the form for use under this paragraph, with input from consumers and providers. The form must be approved by the office of the state coordinator for health information technology within the Governor's office of health policy and finance. [2011, c. 691, Pt. A, §20 (RPR).]

E. A health care practitioner, health care facility or other entity participating in a state-designated statewide health information exchange shall communicate to the exchange the decision of each patient who has declined participation and shall do so within a reasonable time frame, but not more than 2 business days following the receipt of a signed form, as described in paragraph D, from the patient, or shall establish a mechanism by which the patient may decline participation in the state-designated statewide health information exchange at no cost to the patient. [2011, c. 691, Pt. A, §20 (RPR).]

F. A state-designated statewide health information exchange shall process the request of a patient who has decided not to participate in the state-designated statewide health information exchange within 2 business days of receiving the patient's decision to decline, unless additional time is needed to verify the identity of the patient. A signed authorization from the patient is required before a patient is newly entered or reentered into the system if the patient chooses to begin participation at a later date.

Except as otherwise required by applicable law, regulation or rule or state or federal contract, or when the state-designated statewide health information exchange is acting as the agent of a health care practitioner, health care facility or other entity, the state-designated statewide health information exchange shall remove health information of individuals who have declined participation in the exchange. In no event may health information retained in the state-designated statewide health information exchange as set forth in this paragraph be made available to health care practitioners, health care facilities or other entities except as otherwise required by applicable law, regulation or rule or state or federal contract, or when the health care practitioner, health care facility or other entity is the originator of the information. [2011, c. 691, Pt. A, §20 (RPR).]

G. A state-designated statewide health information exchange shall establish a secure website accessible to patients. This website must:

- (1) Permit a patient to request a report of who has accessed that patient's records and when the access occurred. This report must be delivered to the patient within 2 business days upon verification of the patient's identity by the state-designated statewide health information exchange;
- (2) Provide a mechanism for a patient to decline participation in the state-designated statewide health information exchange; and
- (3) Provide a mechanism for the patient to consent to participation in the state-designated statewide health information exchange if the patient had previously declined participation. [2011, c. 691, Pt. A, §20 (RPR).]

H. A state-designated statewide health information exchange shall establish for patients an alternate procedure to that provided for in paragraph F that does not require Internet access. A health care practitioner, health care facility or other entity participating in the state-designated statewide health information exchange shall provide information about this alternate procedure to all patients. The information must be included on the form identified in paragraph D. [2011, c. 691, Pt. A, §20 (RPR).]

I. A state-designated statewide health information exchange shall maintain records regarding all disclosures of health care information by and through the state-designated statewide health information exchange, including the requesting party and the dates and times of the requests and disclosures. [2011, c. 691, Pt. A, §20 (RPR).]

J. A state-designated statewide health information exchange may not charge a patient or an authorized representative of a patient any fee for access or communication as provided in this subsection. [2011, c. 691, Pt. A, §20 (RPR).]

K. Notwithstanding any provision of this subsection to the contrary, a health care practitioner, health care facility or other entity shall provide the form and communication required by paragraphs D and F to all existing patients following the effective date of this subsection. [2011, c. 691, Pt. A, §20 (RPR).]

L. A state-designated statewide health information exchange shall meet or exceed all applicable federal laws and regulations pertaining to privacy, security and breach notification regarding personally identifiable protected health information, as defined in 45 Code of Federal Regulations, Part 160. If a breach occurs, the state-designated statewide health information exchange shall arrange with its participants for notification of each individual whose protected health information has been, or is reasonably believed by the exchange to have been, breached. For purposes of this paragraph, "breach" has the same meaning as in 45 Code of Federal Regulations, Part 164, as amended. [2011, c. 691, Pt. A, §20 (RPR).]

M. The state-designated statewide health information exchange shall develop a quality management plan, including auditing mechanisms, in consultation with the office of the state coordinator for health information technology within the department, who shall review the plan and results. [2011, c. 691, Pt. A, §20 (RPR).]

[2011, c. 691, Pt. A, §20 (RPR).]

**20. Exemption from freedom of access laws.** Except as provided in this section, the names and other identifying information of individuals in a state-designated statewide health information exchange are confidential and are exempt from the provisions of Title 1, chapter 13.

[ 2011, c. 373, §4 (NEW) .]

#### SECTION HISTORY

RR 1997, c. 2, §44 (COR). 1997, c. 793, §A8 (NEW). 1997, c. 793, §A10 (AFF). 1999, c. 3, §§1,2 (AMD). 1999, c. 3, §§3,5 (AFF). 1999, c. 512, §A5 (AMD). 1999, c. 512, §A6, 7 (AFF). 1999, c. 790, §§A58,60 (AFF). RR 2001, c. 1, §26 (COR). 2001, c. 346, §1 (AMD). 2009, c. 211, Pt. B, §17 (AMD). 2009, c. 292, §3 (AMD). 2009, c. 292, §6 (AFF). 2009, c. 387, §§1, 2 (AMD). 2011, c. 347, §§6-8 (AMD). 2011, c. 373, §§1-4 (AMD). 2011, c. 572, §1 (AMD). 2011, c. 691, Pt. A, §20 (AMD). 2013, c. 289, §§1, 2 (AMD). 2013, c. 326, §1 (AMD). 2013, c. 528, §1 (AMD). 2013, c. 528, §12 (AFF).

## §1711-D. DESIGNATION OF VISITORS IN HOSPITAL SETTINGS

**1. Designation of visitors.** A patient in a hospital licensed pursuant to chapter 405 may designate persons to be considered as immediate family members for the purpose of granting visitation rights. The following provisions apply to the designation of visitors under this section.

A. The patient must be 18 years of age or older or a minor who is authorized by law to consent to health care. [2001, c. 378, §1 (NEW).]

B. The patient must be a patient in a critical care unit that restricts visitors to immediate family members, or emergency room that restricts visitors to immediate family members. [2001, c. 378, §1 (NEW).]

C. The patient may designate visitors under this section by communicating the designation to a health care provider at the hospital orally or in writing. The patient may designate visitors, change the designation or revoke the designation at any time. [2001, c. 378, §1 (NEW).]

D. A hospital shall provide to patients in the hospital a process by which to designate visitors under this section and shall note in the patient's medical record the names of designated visitors, the date of the designation and any changes in the designation. [2001, c. 378, §1 (NEW).]

E. Except as provided in subsection 2, a hospital may not deny visitation to the patient by a designated visitor during hospital visiting hours. [2001, c. 378, §1 (NEW).]

[ 2001, c. 378, §1 (NEW) .]

**2. Exceptions.** A hospital may deny visitation with a patient to any visitor designated under this section if:

A. The hospital denies all visitors; [2001, c. 378, §1 (NEW).]

B. The hospital determines that the presence of the visitor might endanger the health or safety of the patient or interfere with the primary operations of the hospital; or [2001, c. 378, §1 (NEW).]

C. The patient has communicated orally or in writing the choice not to visit with the visitor. [2001, c. 378, §1 (NEW).]

[ 2001, c. 378, §1 (NEW) .]

**3. Rulemaking.** By March 1, 2002, the department shall adopt rules to implement this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[ 2001, c. 378, §1 (NEW) . ]

#### SECTION HISTORY

2001, c. 378, §1 (NEW) .

## §1711-E. CONFIDENTIALITY OF PRESCRIPTION DRUG INFORMATION

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Carrier" has the same meaning as in Title 24-A, section 4301-A, subsection 3. [ 2005, c. 589, §1 (NEW) . ]

A-1. "Administrator" has the same meaning as in Title 24-A, section 1901, subsection 1. [ 2007, c. 460, §1 (NEW) . ]

A-2. "Detailing" means one-to-one contact with a prescriber or employees or agents of a prescriber for the purpose of increasing or reinforcing the prescribing of a certain drug by the prescriber. [ 2007, c. 460, §1 (NEW) . ]

B. "Electronic transmission intermediary" means an entity that provides the infrastructure that connects the computer systems or other electronic devices used by and between health care practitioners, prescribers, pharmacies, health care facilities, pharmacy benefit managers, carriers and administrators and agents and contractors of those persons and entities in order to facilitate the secure transmission of an individual's prescription drug order, refill, authorization request, claim, payment or other prescription drug information. [ 2007, c. 460, §1 (AMD) . ]

C. "Health care facility" has the same meanings as in section 1711-C, subsection 1, paragraph D. [ 2005, c. 589, §1 (NEW) . ]

D. "Health care practitioner" has the same meanings as in section 1711-C, subsection 1, paragraph F. [ 2005, c. 589, §1 (NEW) . ]

E. "Health plan" means a health plan providing prescription drug coverage as authorized under the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173. [ 2005, c. 589, §1 (NEW) . ]

F. "Individual" means a natural person who is the subject of prescription drug information. [ 2005, c. 589, §1 (NEW) . ]

F-1. "Marketing" means any of the following activities undertaken or materials or products made available to prescribers or to their employees or agents related to the transfer of prescription drugs from the producer or seller to the consumer or buyer:

- (1) Advertising, publicizing, promoting or selling a prescription drug;
- (2) Activities undertaken for the purpose of influencing the market share of a prescription drug or the prescribing patterns of a prescriber, a detailing visit or a personal appearance;
- (3) Activities undertaken to evaluate or improve the effectiveness of a professional detailing sales force; or
- (4) A brochure, media advertisement or announcement, poster or free sample of a prescription drug.

"Marketing" does not include pharmacy reimbursement, formulary compliance, pharmacy file transfers in response to a patient request or as a result of the sale or purchase of a pharmacy, patient care management, utilization review by a health care provider or agent of a health care provider or the patient's health plan or an agent of the patient's health plan, and health care research. [ 2007, c. 460, §1 (NEW) . ]

F-2. "Pharmacy" means a mail order prescription pharmacy as defined in Title 32, section 13702-A, subsection 17 or a pharmacy as defined in Title 32, section 13702-A, subsection 24. [2007, c. 695, Pt. C, §6 (AMD).]

G. "Pharmacy benefits manager" has the same meaning as in Title 24-A, section 1913, subsection 1, paragraph A. [2011, c. 443, §1 (AMD).]

G-1. "Prescriber" means a person who is licensed, registered or otherwise authorized in the appropriate jurisdiction to prescribe and administer drugs in the course of professional practice. [2007, c. 460, §1 (NEW).]

H. "Prescription drug information" means information concerning prescription drugs as defined in Title 32, section 13702-A, subsection 30 and includes prescription drug orders as defined in Title 32, section 13702-A, subsection 31. [2007, c. 695, Pt. C, §7 (AMD).]

I. "Prescription drug information intermediary" means a person or entity that communicates, facilitates or participates in the exchange of prescription drug information regarding an individual or a prescriber. "Prescription drug information intermediary" includes, but is not limited to, a pharmacy benefits manager, a health plan, an administrator and an electronic transmission intermediary and any person or entity employed by or contracted to provide services to that entity. [2007, c. 460, §1 (AMD).]

[2011, c. 443, §1 (AMD).]

#### **1-A. Findings.**

[2011, c. 494, §1 (RP).]

#### **1-B. Purposes.**

[2011, c. 494, §2 (RP).]

**2. Confidentiality of prescription drug information that identifies the individual.** A carrier or prescription drug information intermediary may not license, use, sell, transfer or exchange for value, for any marketing purpose, prescription drug information that identifies directly or indirectly the individual who is prescribed the prescription drug.

[2011, c. 494, §3 (AMD).]

#### **2-A. Confidentiality of prescription drug information that identifies the prescriber.**

[2011, c. 494, §4 (RP).]

**3. Enforcement.** A violation of subsection 2 is a violation of the Maine Unfair Trade Practices Act.

[2011, c. 494, §5 (AMD).]

#### **4. Confidentiality protection procedures.**

[2011, c. 494, §6 (RP).]

**5. Rules.** The department shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

[2011, c. 90, Pt. J, §10 (AMD).]

#### **SECTION HISTORY**

2005, c. 589, §1 (NEW). 2007, c. 460, §1 (AMD). 2007, c. 695, Pt. C, §§6, 7 (AMD). 2011, c. 90, Pt. J, §10 (AMD). 2011, c. 443, §1 (AMD). 2011, c. 461, §1 (AMD). 2011, c. 494, §§1-6 (AMD).

## **§1711-F. TRANSFER OF MEMBER HEALTH CARE INFORMATION BY MAINECARE PROGRAM FOR PURPOSE OF DIAGNOSIS, TREATMENT OR CARE**

The MaineCare program established under chapter 855 may transfer member health care information to a health care practitioner or health care facility for the purpose of diagnosis, treatment or care of the member through an electronic health information exchange in accordance with this section. [2009, c. 387, §3 (NEW).]

**1. Definitions.** For the purposes of this section, "health care facility" has the same meaning as in section 1711-C, subsection 1, paragraph D and "health care practitioner" has the same meaning as in section 1711-C, subsection 1, paragraph F.

[2009, c. 387, §3 (NEW).]

**2. Individual protection mechanism.** The department shall provide an individual protection mechanism for MaineCare members by which an individual may prohibit a health information exchange from disclosing the individual's health care information to a health care practitioner or health care facility.

[2009, c. 387, §3 (NEW).]

**3. Health care information subject to other laws, rules and regulations.** Health care information that is subject to the provisions of 42 United States Code, Section 290dd-2 (Supplement 1998); chapters 710-B and 711; Title 5, section 200-E; Title 5, chapter 501; Title 24 or 24-A; Title 34-B, section 1207; Title 39-A; or other confidentiality provisions of state or federal law, rule or regulation is governed solely by those provisions.

[2009, c. 387, §3 (NEW).]

### **SECTION HISTORY**

2009, c. 387, §3 (NEW).

## **§1712. ITEMIZED BILLS**

Each hospital licensed by the State under chapter 405 shall inform all patients, or their legal guardians, in writing, at the time of the patient's discharge, that it will provide an itemized bill upon their request. [1983, c. 166, (NEW).]

The request may be made by the patient or his legal guardian at discharge or at any time within 7 years after discharge. [1983, c. 166, (NEW).]

The hospital shall provide an itemized bill to the person making the request within 30 days of the request. [1983, c. 166, (NEW).]

Notwithstanding this section, effective July 1, 1985, each hospital shall itemize on the hospital bill of each patient the cost of nursing services provided to that patient. [1983, c. 166, (NEW).]

### **SECTION HISTORY**

1983, c. 166, (NEW).

## **§1713. TRANSITIONAL HOSPITAL REIMBURSEMENT (REPEALED)**



## SECTION HISTORY

1983, c. 824, §X2 (NEW). 2007, c. 466, Pt. A, §41 (RP).

**§1714. DEBTS OWED THE DEPARTMENT BY PROVIDERS**

*(REPEALED)*

## SECTION HISTORY

1989, c. 34, (NEW). 1991, c. 9, §G3 (RP).

**§1714-A. DEBTS OWED THE DEPARTMENT BY PROVIDERS**

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Boarding home" means any facility that meets the definition of former section 7901-A, subsection 4 or the definition of residential care facility in section 7852, subsection 14. [2001, c. 596, Pt. B, §3 (AMD); 2001, c. 596, Pt. B, §25 (AFF).]

B. "Debt" means any amount of money that is owed to the department as a result of:

- (1) Overpayments that have been determined by a department audit pursuant to the applicable principles of reimbursement, overpayments as reported by a provider in an unaudited cost report or overpayments that have been discovered in any other manner;
- (2) The department's authority to recapture depreciation;
- (3) The assessment of fines and sanctions;
- (4) Projected overpayments reported in an interim cost report. If an interim report is not filed at least 30 days prior to the transfer, "debt" also includes 5% of Medicaid reimbursement or cost reimbursement for the last fiscal year or \$50,000, whichever is less; or
- (5) A final reconciliation decision and order by the former Maine Health Care Finance Commission. [2007, c. 466, Pt. A, §42 (AMD).]

C. "Former provider" means the person reimbursed by the department for the provision of health care services at a nursing home, boarding home, hospital or other provider of health care services prior to its transfer. [2011, c. 687, §5 (AMD).]

D. "Hospital" means any facility licensed pursuant to sections 1811 and 1817. [1991, c. 9, Pt. G, §4 (NEW).]

E. "Interim cost report" means a cost report that covers the current fiscal year and any prior periods not covered by a previously filed cost report. Cost incurred in the 90 days prior to the transfer need not be covered in the interim cost report. [1991, c. 9, Pt. G, §4 (NEW).]

F. "Nursing home" means any facility that meets the definition of section 1812-A, including an intermediate care facility for persons with intellectual disabilities. [2011, c. 542, Pt. A, §27 (AMD).]

G. "Person" means any natural person, partnership, association, corporation or other entity including any county, local or other governmental unit. [1991, c. 9, Pt. G, §4 (NEW).]

H. "Provider" means a person reimbursed by the department for the provision of health care services. [1991, c. 9, Pt. G, §4 (NEW).]

I. "Transfer" means any change in the ownership or control of a nursing home, boarding home, hospital or other provider of health care services, including, but not limited to, a sale, lease or gift of the land, building or operating entity, that results in:

(1) The department reimbursing a person other than the former provider for the provision of care or services; or

(2) The discontinuation of the provision of care or services. [2011, c. 687, §6 (AMD).]

J. "Transferee" means any person to whom a nursing home, boarding home, hospital or other provider of health care services is transferred. [2011, c. 687, §6 (AMD).]

[ 2011, c. 542, Pt. A, §27 (AMD); 2011, c. 687, §§5, 6 (AMD) .]

**2. Establishment of debt.** A debt is established by the department when it notifies a provider of debt that the provider owes the department pursuant to a decision and order that constitutes final agency action. A debt is collectible by the department 31 days after exhaustion of all administrative appeals and any judicial review available under Title 5, chapter 375.

[ 2003, c. 419, §4 (AMD) .]

**3. Notice of debt.** Any notice of debt issued to a provider by the department must include the following:

A. A statement of the debt accrued; [1991, c. 9, Pt. G, §4 (NEW).]

B. A statement of the time period during which the debt accrued; [1991, c. 9, Pt. G, §4 (NEW) .]

C. The basis for the debt; [1991, c. 9, Pt. G, §4 (NEW).]

D. The debtor's right to request a fair hearing within 30 days of receipt of the notice; and [1991, c. 9, Pt. G, §4 (NEW).]

E. A statement that after a debt is established, the department may proceed to collect that debt through administrative offset, lien and foreclosure, or other collection action. [1991, c. 9, Pt. G, §4 (NEW) .]

[ 1991, c. 568, §1 (AMD) .]

**4. Successor liability.** Liability of transferees is governed by this subsection.

A. When a nursing home, boarding home, hospital or other provider of health care services is transferred, the transferee is liable for debts owed to the department by the former provider unless by the time of sale:

(1) All debts owed by the former provider to the department have been paid, except as stated in subparagraph (2);

(2) If the indebtedness is the subject of an administrative appeal, an escrow account has been created and funded in an amount sufficient to cover the debt as claimed by the department; or

(3) An interim cost report has:

(a) Been filed and an escrow account has been created and funded in an amount sufficient to cover any overpayment identified in the report; or

(b) Not been filed and an escrow account has been created and funded in an amount sufficient to cover 5% of Medicaid reimbursement or cost reimbursement for the last fiscal year or \$50,000, whichever is less. [2011, c. 687, §7 (AMD).]

B. Any person affected by this subsection may request that the department identify the amount of any debt owed by a nursing home, boarding home, hospital or other provider of health care services. When the department receives such a request, it shall identify the debt within 30 days. Failure to identify the amount of a debt when a request is made in writing at least 30 days prior to the transfer precludes the department from recovering that debt from the transferee. [2011, c. 687, §7 (AMD).]

C. The department shall provide written notice of the requirements of this section to the transferee in a letter acknowledging receipt of a request for a certificate of need or waiver of the certificate of need for a nursing home or hospital transfer or in response to a request for an application for a license to operate a boarding home or to provide other health care services. [2011, c. 687, §8 (AMD).]

D. If a transferee becomes liable for a debt pursuant to this subsection, the transferee shall succeed to any defenses to the debt that could have been exercised by the former provider. [1991, c. 9, Pt. G, §4 (NEW).]

E. Nothing in this subsection may limit the liability of the former provider to the department for any debts whether or not they are identified at the time of sale. In addition, a transferee has a cause of action against a former provider to the extent that debts of the former provider are paid by the transferee, unless the transferee has waived the right to sue the former provider for those debts. [1991, c. 568, §2 (AMD).]

F. The commissioner may waive all or part of a transferee's liability under this subsection if the commissioner finds that a waiver of liability is in the public interest. [1991, c. 568, §3 (NEW).]

[2011, c. 687, §§7, 8 (AMD).]

**5. Department may offset.** The department may offset against current reimbursement owed to a provider or any entity related by ownership or control to that provider any debt it is owed by that provider after the debt becomes collectible. The department shall adopt rules that implement this subsection and define the ownership or control relationships that are subject to an offset under this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2003, c. 419, §5 (AMD).]

**6. Liens.** Collection by lien is as follows.

A. After a debt is collectible, the amount stated in the notice of debt or overpayment is a lien in favor of the department against all real or personal property of the provider or any entity related by ownership or control to the provider. [1991, c. 568, §4 (NEW).]

B. The lien attaches to all real and personal property of the responsible party when the department files in the registry of deeds of any county, or with any office appropriate for a notice with respect to personal property, a certificate that states the name of the responsible party, that party's address, the amount of debt accrued, the date of the underlying audit or decision and the name and address of the authorized agent of the department who issues the lien. [1991, c. 568, §4 (NEW).]

C. When a lien has been filed and the person having notice of the lien possesses any property that may be subject to the lien, that property may not be paid over, released, sold, transferred, encumbered or conveyed unless:

- (1) A release or waiver signed by the commissioner has been delivered to the person in possession of the property; or
- (2) A court has ordered the release of the lien. A court may order a release only when alternative security has been provided for the debt owed the department. [1991, c. 568, §4 (NEW).]

D. The commissioner may hold title to real or personal property for the purpose of foreclosure on filed liens. Foreclosure must proceed as follows.

- (1) Actions to foreclose liens on real property filed under this subsection may be brought in the county where the lien is filed pursuant to the procedures of Title 14, chapter 713, subchapter VI. For purposes of foreclosure by civil action as described in Title 14, chapter 713, subchapter VI, a lien filed in accordance with this subsection constitutes a mortgage claim of the department on any real property owned by the debtor. Failure to pay the debt owed the department constitutes a breach of condition in the mortgage.

(2) Actions to foreclose liens on personal property filed under this subsection may be brought, pursuant to Title 14, chapter 509, subchapter III, in the county where the lien is filed. [ 1991, c. 568, §4 (NEW) .]

[ 1991, c. 568, §4 (NEW) .]

**7. Other collection actions.** In addition to the other remedies provided in this section, the department may seek collection of any debt established under subsection 2 pursuant to Title 14, chapter 502, Title 36, chapter 7 and Title 36, section 5276-A.

A business entity, including a sole proprietorship, is considered out of business for the purposes of the department's recovering indebtedness if, after reasonable investigation, the department or its legal counsel has certified in writing that the business entity is no longer conducting operations and that there is no realistic expectation of collecting any significant money from the entity based upon one or more of the following conditions:

A. The business entity has ceased offering retail or wholesale goods and services to the public; [ 2003, c. 673, Pt. YYY, §1 (NEW) .]

B. Upon reasonable investigation, nonexempt assets of the business entity of substantial value can not be identified or are otherwise unavailable for attachment and recovery; [ 2003, c. 673, Pt. YYY, §1 (NEW) .]

C. The business entity's physical location or locations of business are closed to the public; [ 2003, c. 673, Pt. YYY, §1 (NEW) .]

D. The business entity's corporate status is no longer in good standing; [ 2003, c. 673, Pt. YYY, §1 (NEW) .]

E. The business entity has admitted that it has insufficient assets to satisfy the debt; [ 2007, c. 2, §8 (COR) .]

F. After reasonable investigation, the department or its counsel can not locate the business entity or identify the debtor's nonexempt assets; and [ 2003, c. 673, Pt. YYY, §1 (NEW) .]

G. The business entity has transferred substantially all of its business assets to a 3rd party and there are no recoverable assets as a result of the transfer. [ 2003, c. 673, Pt. YYY, §1 (NEW) .]

Certification by the department that a business entity is out of business under this subsection does not preclude further collection and recovery procedures by the department, whether to formally adjudicate the indebtedness or to proceed with collection and recovery if the department becomes aware of facts that merit further recovery efforts.

[ 2007, c. 2, §8 (COR) .]

**8. Rulemaking.** The department may adopt or amend any rule as necessary to implement this section.

[ 1991, c. 568, §4 (NEW) .]

**9. Cost-of-care overpayments.** On or before June 30, 2015, the department shall collect the total amount of debt arising from cost-of-care overpayments that exceeds by \$4,000,000 the amount of that debt that had been budgeted for fiscal year 2014-15 as of April 15, 2014. To the extent necessary to meet this requirement, the department may establish payment terms, modify as otherwise permitted by law existing payment agreements to accelerate payment terms and offset current payments in accordance with subsection 5. If 7 days' notice and opportunity to comment are provided, the department may adopt rules

on an emergency basis to modify its implementation of subsection 5 on an emergency basis for purposes of collecting cost-of-care overpayments without making the emergency findings otherwise required by Title 5, section 8054, subsection 2.

[ 2013, c. 594, §2 (NEW) .]

#### SECTION HISTORY

1991, c. 9, §G4 (NEW). 1991, c. 568, §§1-4 (AMD). 2001, c. 596, §§B3,4 (AMD). 2001, c. 596, §B25 (AFF). 2003, c. 419, §§4,5 (AMD). 2003, c. 673, §YYY1 (AMD). RR 2007, c. 2, §8 (COR). 2007, c. 466, Pt. A, §42 (AMD). 2007, c. 539, Pt. OO, §1 (AMD). 2011, c. 542, Pt. A, §27 (AMD). 2011, c. 687, §§5-8 (AMD). 2013, c. 594, §2 (AMD).

### **§1714-B. CRITICAL ACCESS HOSPITAL REIMBURSEMENT**

*(REPEALED)*

#### SECTION HISTORY

2005, c. 12, §ZZZ1 (NEW). 2005, c. 342, §1 (AMD). 2005, c. 342, §2 (AFF). 2005, c. 519, §PP1 (AMD). 2009, c. 213, Pt. CC, §1 (AMD). MRSA T. 22, §1714-B (RP).

### **§1714-C. CRITICAL ACCESS HOSPITAL STAFF ENHANCEMENT REIMBURSEMENT**

Beginning April 1, 2011, the department shall reimburse critical access hospitals from the total allocated from hospital tax revenues under Title 36, chapter 377 at least \$1,000,000 in state and federal funds to be distributed annually among critical access hospitals for staff enhancement payments. [2011, c. 548, §8 (AMD).]

#### SECTION HISTORY

2009, c. 213, Pt. CC, §2 (NEW). 2011, c. 548, §8 (AMD).

### **§1714-D. CRITICAL ACCESS HOSPITAL REIMBURSEMENT**

Beginning April 1, 2012, the department shall reimburse licensed critical access hospitals at 109% of MaineCare allowable costs for both inpatient and outpatient services provided to patients covered by the MaineCare program. Of the total allocated from hospital tax revenues under Title 36, chapter 375, \$1,000,000 in state and federal funds must be distributed annually among critical access hospitals for staff enhancement payments. [2011, c. 657, Pt. H, §1 (NEW); 2011, c. 657, Pt. H, §5 (AFF).]

*§1714-D. Credible allegations of fraud; provider payment suspensions*

*(As enacted by PL 2011, c. 687, §9 is REALLOCATED TO TITLE 22, SECTION 1714-E)*

#### SECTION HISTORY

RR 2011, c. 2, §25 (RAL). 2011, c. 657, Pt. H, §1 (NEW). 2011, c. 657, Pt. H, §5 (AFF). 2011, c. 687, §9 (NEW).

### **§1714-E. CREDIBLE ALLEGATIONS OF FRAUD; PROVIDER PAYMENT SUSPENSIONS**

*(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)*

*(WHOLE SECTION TEXT REPEALED ON CONTINGENCY: See T. 22, §1714-E, sub-§7)*

If the department determines that there is a credible allegation of fraud by a provider under the MaineCare program, the following procedures apply. [ 2011, c. 2, §25 (RAL) . ]

**1. Suspension of payments.** The department shall suspend payment in whole or in part to a MaineCare provider when a suspension is necessary to comply with Section 6402(h)(2) of the federal Patient Protection and Affordable Care Act of 2010, Public Law 111-148 and 42 Code of Federal Regulations, Part 455.

[ 2011, c. 2, §25 (RAL) . ]

**2. Administrative appeal; scope.** A MaineCare provider may administratively appeal the department's decision to suspend payment under subsection 1.

[ 2011, c. 2, §25 (RAL) . ]

**3. No stay during administrative appeal.** A suspension of payments under subsection 1 may not be stayed during an administrative appeal of the department's decision to suspend payment. The department may provide a fair opportunity for appropriate expedited relief from a suspension of payments consistent with federal law.

[ 2011, c. 2, §25 (RAL) . ]

**4. Final determination; offset.** Upon a final determination that fraud has occurred and that money is owed by the MaineCare provider to the department, and 31 days after exhaustion of all administrative appeals and any judicial review available under Title 5, chapter 375, the department may retain and apply as an offset to amounts determined to be owed to the department any payments to the provider that were suspended by the department pursuant to this section. The amount retained pursuant to this subsection may not exceed the amount determined finally to be owed.

[ 2011, c. 2, §25 (RAL) . ]

**5. Confidentiality.** Except as necessary for purposes of the investigation of fraud or the administration of the MaineCare program, the department's records regarding a determination of a credible allegation of fraud are confidential until the relevant MaineCare provider has been given notice of a suspension of payments under subsection 1.

[ 2011, c. 2, §25 (RAL) . ]

**6. Rules.** The department shall adopt rules to implement this section, including rules to define "credible allegation of fraud" and to provide exception and appeal procedures as required by and in accordance with the requirements of federal law and regulations. If the department provides a procedure for expedited relief from suspension of payments, as authorized in subsection 3, the rules must include that procedure. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[ 2011, c. 2, §25 (RAL) . ]

**7. Repeal.** This section is repealed if Section 6402(h)(2) of the federal Patient Protection and Affordable Care Act of 2010, Public Law 111-148 and 42 Code of Federal Regulations, Part 455 are invalidated by the United States Supreme Court.

[ 2011, c. 2, §25 (RAL) . ]

#### SECTION HISTORY

RR 2011, c. 2, §25 (RAL) .

## §1715. ACCESS REQUIREMENTS APPLICABLE TO CERTAIN HEALTH CARE PROVIDERS

**1. Access requirements.** Any person, including, but not limited to an affiliated interest as defined in section 396-L, that is subject to the requirements of this subsection, shall provide the services listed in paragraph C to individuals who are eligible for charity care in accordance with a charity care policy adopted by the affiliate or provider that is consistent with rules applicable to hospitals under section 1716. A person is subject to this subsection if that person:

A. Is either a direct provider of major ambulatory service, as defined in section 382, subsection 8-A, or is or has been required to obtain a certificate of need under section 329 or former section 304 or 304-A; [2001, c. 2, Pt. A, §34 (COR).]

B. Provides outpatient services as defined in section 382, subsection 9-A; and [1989, c. 919, §15 (NEW); 1989, c. 919, §18 (AFF).]

C. Provides one or more of the following services:

(1) Imaging services, including, but not limited to, magnetic resonance imaging, computerized tomography, mammography and radiology. For purposes of this section, imaging services do not include:

(a) Screening procedures that are not related to the diagnosis or treatment of a specific condition; or

(b) Services when:

(i) The services are owned by a community health center, a physician or group of physicians;

(ii) The services are offered solely to the patients of that center, physician or group of physicians; and

(iii) Referrals for the purpose of performing those services are not accepted from other physicians;

(2) Laboratory services performed by a hospital or by a medical laboratory licensed in accordance with the Maine Medical Laboratory Commission, or licensed by an equivalent out-of-state licensing authority, excluding those licensed laboratories owned by community health centers, a physician or group of physicians where the laboratory services are offered solely to the patients of that center, physician or group of physicians;

(3) Cardiac diagnostic services, including, but not limited to, cardiac catheterization and angiography but excluding electrocardiograms and electrocardiograph stress testing;

(4) Lithotripsy services;

(5) Services provided by free-standing ambulatory surgery facilities certified to participate in the Medicare program; or

(6) Any other service performed in an out-patient setting requiring the purchase of medical equipment costing in the aggregate \$500,000 or more and for which the charge per unit of service is \$250 or more. [1989, c. 919, §15 (NEW); 1989, c. 919, §18 (AFF).]

[ 2001, c. 2, Pt. A, §34 (COR) .]

**2. Enforcement.** The requirements of subsection 1 are enforced through the following mechanisms.

A. Any person who knowingly violates any provision of this section or any valid order or rule made or adopted pursuant to section 1716, or who willfully fails, neglects or refuses to perform any of the duties imposed under this section, commits a civil violation for which a forfeiture of not less than \$200 and not more than \$500 per patient may be adjudged with respect to each patient denied access unless

specific penalties are elsewhere provided. Any forfeiture imposed under this section may not exceed \$5,000 in the case of the first judgment under this section against the provider, \$7,500 in the case of a 2nd judgment against the provider or \$10,000 in the case of the 3rd or subsequent judgment against the provider. The Attorney General is authorized to prosecute the civil violations. [1995, c. 653, Pt. B, §6 (AMD); 1995, c. 653, Pt. B, §8 (AFF); 1995, c. 696, Pt. A, §35 (AMD).]

B. Upon application of the Attorney General or any affected patient, the Superior Court or District Court has full jurisdiction to enforce the performance by providers of health care of all duties imposed upon them by this section and any valid rules adopted pursuant to section 1716. [1995, c. 653, Pt. B, §6 (AMD); 1995, c. 653, Pt. B, §8 (AFF); 1995, c. 696, Pt. A, §35 (AMD).]

C. In any civil action under this section, the court, in its discretion, may allow the prevailing party, other than the Attorney General, reasonable attorney's fees and costs and the Attorney General is liable for attorney's fees and costs in the same manner as a private person. [1989, c. 919, §15 (NEW); 1989, c. 919, §18 (AFF).]

D. It is an affirmative defense to any legal action brought under this section that the person subject to this section denied access to services on the grounds that the economic viability of the facility or practice would be jeopardized by compliance with this section. [1989, c. 919, §15 (NEW); 1989, c. 919, §18 (AFF).]

[ 1995, c. 653, Pt. B, §6 (AMD); 1995, c. 653, Pt. B, §8 (AFF); 1995, c. 696, Pt. A, §35 (AMD) .]

#### SECTION HISTORY

1989, c. 919, §§15,18 (NEW). 1995, c. 653, §§B5,6 (AMD). 1995, c. 653, §B8 (AFF). 1995, c. 696, §§A34,35 (AMD). RR 2001, c. 2, §A34 (COR).

## §1716. CHARITY CARE GUIDELINES

The department shall adopt reasonable guidelines for policies to be adopted and implemented by hospitals with respect to the provision of health care services to patients who are determined unable to pay for the services received. The department shall adopt income guidelines that are consistent with the guidelines applicable to the Hill-Burton Program established under 42 United States Code, Section 291, et seq. (1995). The guidelines and policies must include the requirement that upon admission or, in cases of emergency admission, before discharge of a patient, hospitals must investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. The guidelines must include provisions for notice to the public and the opportunity for a fair hearing regarding eligibility for charity care. [1995, c. 653, Pt. B, §7 (NEW); 1995, c. 653, Pt. B, §8 (AFF); 1995, c. 696, Pt. A, §36 (NEW).]

#### SECTION HISTORY

1995, c. 653, §B7 (NEW). 1995, c. 653, §B8 (AFF). 1995, c. 696, §A36 (NEW).

## §1717. REGISTRATION OF PERSONAL CARE AGENCIES AND PLACEMENT AGENCIES

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.



A. "Activities of daily living" means tasks that are routinely performed by an individual to maintain bodily function, including, but not limited to, mobility; transfers in position among sitting, standing and prone positions; dressing; eating; toileting; bathing; and personal hygiene assistance. [1997, c. 716, §1 (NEW).]

B. "Hires and employs" means recruits, selects, trains, declares competent, schedules, directs, defines the scope of the positions of, supervises or terminates individuals who provide personal care. [1997, c. 716, §1 (NEW).]

B-1. "Home care services" means assistance with activities of daily living and related tasks. [2007, c. 324, §2 (NEW).]

C. "Personal care agency" means a business entity or subsidiary of a business entity that is not otherwise licensed by the Division of Licensing and Regulatory Services and that hires and employs unlicensed assistive personnel to provide assistance with activities of daily living and related tasks to individuals in the places in which they reside, either permanently or temporarily. An individual who hires and employs unlicensed assistive personnel to provide care for that individual is not a personal care agency, except when permitted by rule of the department. [2007, c. 324, §2 (AMD).]

C-1. "Placement agency" means any person or entity engaged for gain or profit in the business of securing or attempting to secure home care services work for an individual or of securing or attempting to secure a home care services worker for a consumer. "Placement agency" includes, but is not limited to, employment agencies, nurse registries and any other entity that places a home care services worker for hire by a consumer in that consumer's temporary or permanent residence for purposes of providing home care services. [2007, c. 324, §2 (NEW).]

D. "Unlicensed assistive personnel" means individuals employed to provide hands-on assistance with activities of daily living to individuals in homes, assisted living centers, residential care facilities, hospitals and other health care settings. "Unlicensed assistive personnel" does not include certified nursing assistants employed in their capacity as certified nursing assistants. [2007, c. 324, §2 (AMD).]

[ 2007, c. 324, §2 (AMD) . ]

**2. Registration of personal care agencies and placement agencies.** Beginning August 1, 1998, a personal care agency not otherwise licensed by the department shall register with the department. Beginning January 1, 2008, a placement agency not otherwise licensed by the department shall register with the department. The department shall adopt rules establishing the annual registration fee, which must be at least \$25.

[ 2007, c. 324, §2 (AMD) . ]

**3. Prohibited employment.** A personal care agency or a placement agency shall obtain criminal history record information about applicants for positions as unlicensed assistive personnel or home care services workers and may not hire or place an individual who:

A. Has worked as a certified nursing assistant and has been the subject of a notation by the state survey agency for a substantiated complaint of abuse, neglect or misappropriation of property in a health care setting that was entered on the Maine Registry of Certified Nursing Assistants and Direct Care Workers; [2011, c. 257, §1 (AMD).]

B. Has been convicted in a court of law of a crime involving abuse, neglect or misappropriation of property in a health care setting; or [2003, c. 634, §1 (NEW).]

C. Has a prior criminal conviction within the last 10 years of:

(1) A crime for which incarceration of 3 years or more may be imposed under the laws of the state in which the conviction occurred; or

(2) A crime for which incarceration of less than 3 years may be imposed under the laws of the state in which the conviction occurred involving sexual misconduct or involving abuse, neglect or exploitation in a setting other than a health care setting. [2003, c. 634, §1 (NEW).]

[2011, c. 257, §1 (AMD).]

**4. Penalties.** The following penalties apply to violations of this section.

A. A person who operates a personal care agency or placement agency without registering with the department as required by subsection 2 commits a civil violation for which a fine of not less than \$500 per day of operation but not more than \$10,000 may be adjudged. Each day of violation constitutes a separate offense. [2007, c. 324, §2 (AMD).]

B. A person who operates a personal care agency or placement agency in violation of the employment prohibitions in subsection 3 commits a civil violation for which a fine of not less than \$500 per day of operation in violation but not more than \$10,000 per day may be adjudged, beginning on the first day that a violation occurs. Each day of violation constitutes a separate offense. [2007, c. 324, §2 (AMD).]

[2007, c. 324, §2 (AMD).]

**5. Injunctive relief.** Notwithstanding any other remedies provided by law, the Office of the Attorney General may seek an injunction to require compliance with the provisions of this section.

[2007, c. 324, §2 (NEW).]

**6. Enforcement.** The Office of the Attorney General may file a complaint with the District Court seeking civil penalties or injunctive relief or both for violations of this section.

[2007, c. 324, §2 (NEW).]

**7. Jurisdiction.** The District Court has jurisdiction pursuant to Title 4, section 152 for violations of this section.

[2007, c. 324, §2 (NEW).]

**8. Burden of proof.** The burden is on the department to prove, by a preponderance of the evidence, that the alleged violations of this section occurred.

[2007, c. 324, §2 (NEW).]

**9. Right of entry.** This subsection governs the department's right of entry.

A. An application for registration of a personal care agency or placement agency constitutes permission for entry and inspection to verify compliance with applicable laws and rules. [2007, c. 324, §2 (NEW).]

B. The department has the right to enter and inspect the premises of a personal care agency or placement agency registered by the department at a reasonable time and, upon demand, has the right to inspect and copy any books, accounts, papers, records and other documents in order to determine the state of compliance with applicable laws and rules. [2007, c. 324, §2 (NEW).]

C. To inspect a personal care agency or placement agency that the department knows or believes is being operated without being registered, the department may enter only with the permission of the owner or person in charge or with an administrative inspection warrant issued pursuant to the Maine Rules of Civil Procedure, Rule 80E by the District Court authorizing entry and inspection. [ 2007, c. 324, §2 (NEW) . ]

[ 2007, c. 324, §2 (NEW) . ]

**10. Administrative inspection warrant.** The department and a duly designated officer or employee of the department have the right to enter upon and into the premises of an unregistered personal care agency or placement agency with an administrative inspection warrant issued pursuant to the Maine Rules of Civil Procedure, Rule 80E by the District Court at a reasonable time and, upon demand, have the right to inspect and copy any books, accounts, papers, records and other documents in order to determine the state of compliance with this section. The right of entry and inspection may extend to any premises and documents of a person, firm, partnership, association, corporation or other entity that the department has reason to believe is operating without being registered.

[ 2007, c. 324, §2 (NEW) . ]

**11. Noninterference.** An owner or operator of an unregistered personal care agency or placement agency may not interfere with, impede or obstruct an investigation by the department, including but not limited to interviewing persons receiving services or persons with knowledge of the agency.

[ 2007, c. 324, §2 (NEW) . ]

**12. Violation of injunction.** A person, firm, partnership, association, corporation or other entity that violates the terms of an injunction issued under this section shall pay to the State a fine of not less than \$500 nor more than \$10,000 for each violation. Each day of violation constitutes a separate offense. In any action brought by the Office of the Attorney General against a person, firm, partnership, association, corporation or other entity for violating the terms of an injunction under this section, the District Court may make the necessary orders or judgments regarding violation of the terms of the injunction.

In an action under this section, when a permanent injunction has been issued, the District Court may order the person, firm, partnership, association, corporation or other entity against which the permanent injunction is issued to pay to the General Fund the costs of the investigation of that person, firm, partnership, association, corporation or other entity by the Office of the Attorney General and the costs of suit, including attorney's fees.

[ 2007, c. 324, §2 (NEW) . ]

**13. Suspension or revocation of registration.** A personal care agency or placement agency found to be in violation of this section may have its registration to operate as a personal care agency or placement agency suspended or revoked. The department may file a complaint with the District Court requesting suspension or revocation of a registration to operate a personal care agency or placement agency.

[ 2007, c. 324, §2 (NEW) . ]

**14. Rules.** The department may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[ 2007, c. 324, §2 (NEW) . ]

#### SECTION HISTORY

1997, c. 716, §1 (NEW). 2003, c. 634, §§1,2 (AMD). 2003, c. 673, §NN1 (AMD). 2007, c. 324, §2 (AMD). 2011, c. 257, §1 (AMD).

## §1718. CONSUMER INFORMATION

Each hospital or ambulatory surgical center licensed under chapter 405 shall, upon request by an individual, provide the average charge for any inpatient service or outpatient procedure provided by the licensee. If a single medical encounter will involve services or procedures to be rendered by one or more 3rd-party health care entities as defined in section 1718-B, subsection 1, paragraph B, the hospital or ambulatory surgical center shall identify each 3rd-party health care entity to enable the individual to seek an estimate of the total price of services or procedures to be rendered directly by each health care entity to that individual. For emergency services, the hospital must provide the average charges for facility and physician services according to the level of emergency services provided by the hospital and based on the time and intensity of services provided. The hospital or ambulatory surgical center shall prominently display a notice informing individuals of an individual's authority to request information on the average charges described in this paragraph from the hospital or ambulatory surgical center. [2013, c. 560, §1 (AMD).]

### 1. Inpatient services.

[2009, c. 71, §3 (RP) .]

### 2. Outpatient nonemergent procedures.

[2009, c. 71, §3 (RP) .]

### 3. Emergency services.

[2009, c. 71, §3 (RP) .]

#### SECTION HISTORY

RR 2003, c. 1, §16 (COR). 2003, c. 469, §C15 (NEW). 2005, c. 391, §1 (AMD). 2009, c. 71, §3 (RPR). 2013, c. 560, §1 (AMD).

## §1718-A. CONSUMER INFORMATION REGARDING HEALTH CARE PRACTITIONER PRICES

*(REPEALED)*

#### SECTION HISTORY

2013, c. 332, §1 (NEW). 2013, c. 332, §3 (AFF). 2013, c. 515, §1 (RP).

## §1718-B. CONSUMER INFORMATION REGARDING HEALTH CARE ENTITY PRICES

This section applies to the disclosure of health care prices by a health care entity. [2013, c. 515, §2 (NEW) .]

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Frequently provided health care services and procedures" means those health care services and procedures that were provided by the health care entity at least 50 times in the preceding calendar year. [2013, c. 515, §2 (NEW) .]

B. "Health care entity" means a health care practitioner, as defined in section 1711-C, subsection 1, paragraph F; a group of health care practitioners; or a health care facility, as defined in section 1711-C, subsection 1, paragraph D, that charges patients for health care services and procedures. A health care entity does not include a pharmacy or a pharmacist. [2013, c. 515, §2 (NEW).]

[ 2013, c. 515, §2 (NEW) .]

**2. Requirements.** The following requirements apply to health care entities.

A. A health care entity shall have available to patients the prices of the health care entity's most frequently provided health care services and procedures. The prices stated must be the prices that the health care entity charges patients directly when there is no insurance coverage for the services or procedures or when reimbursement by an insurance company is denied. The prices stated must be accompanied by descriptions of the services and procedures and the applicable standard medical codes or current procedural technology codes used by the American Medical Association. [2013, c. 515, §2 (NEW).]

B. A health care entity shall inform patients about the availability of prices for the most frequently provided health care services and procedures. [2013, c. 515, §2 (NEW).]

C. A health care entity shall prominently display in a location that is readily accessible to patients information on the price transparency tools available from the publicly accessible website of the Maine Health Data Organization established pursuant to chapter 1683 to assist consumers with obtaining estimates of costs associated with health care services and procedures. [2013, c. 515, §2 (NEW).]

A health care entity that does not routinely render services directly to patients in an office setting may satisfy this subsection by providing the information on its publicly accessible website.

[ 2013, c. 515, §2 (NEW) .]

#### SECTION HISTORY

2013, c. 515, §2 (NEW).

## **§1718-C. ESTIMATE OF THE TOTAL PRICE OF A SINGLE MEDICAL ENCOUNTER FOR AN UNINSURED PATIENT**

Upon the request of an uninsured patient, a health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall provide within a reasonable time of the request an estimate of the total price of medical services to be rendered directly by that health care entity during a single medical encounter. If the health care entity is unable to provide an accurate estimate of the total price of a specific medical service because the amount of the medical service to be consumed during the medical encounter is unknown in advance, the health care entity shall provide a brief description of the basis for determining the total price of that particular medical service. If a single medical encounter will involve medical services to be rendered by one or more 3rd-party health care entities, the health care entity shall identify each 3rd-party health care entity to enable the uninsured patient to seek an estimate of the total price of medical services to be rendered directly by each health care entity to that patient. When providing an estimate as required by this section, a health care entity shall also notify the uninsured patient of any charity care policy adopted by the health care entity. [2013, c. 560, §2 (NEW).]

#### SECTION HISTORY

2013, c. 560, §2 (NEW).

## §1719. PATIENTS' RIGHTS

This section applies to hospitals licensed pursuant to chapter 405 that are nonstate mental health institutions as defined in Title 34-B, section 3801, subsection 6 and that are not subject to the grievance procedures of the Department of Behavioral and Developmental Services. [ 2003, c. 649, §1 (NEW) . ]

**1. Adoption of rules.** The commissioner shall adopt rules for the enhancement and protection of the rights of adult patients receiving inpatient mental health services from a hospital subject to the requirements of this section. The commissioner shall hold a public hearing before adopting rules under this section and shall give notice of the public hearing pursuant to Title 5, section 8053. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[ 2003, c. 649, §1 (NEW) . ]

**2. Rights protected.** The rules adopted pursuant to subsection 1 must meet the requirements of Title 34-B, section 3003, subsection 2, paragraphs A to K and must provide for the same opportunity for hearing and type of hearing as described in rules of the Department of Behavioral and Developmental Services relating to grievances filed by adult mental health consumers.

[ 2003, c. 649, §1 (NEW) . ]

**3. Delegation.** The department shall delegate to the Department of Behavioral and Developmental Services responsibility for hearing and resolving all grievances that are submitted in a timely manner by patients receiving inpatient mental health services in hospitals subject to the requirements of this section.

[ 2003, c. 649, §1 (NEW) . ]

**4. Final agency action.** Final resolution of a grievance by the Department of Behavioral and Developmental Services under the rules adopted pursuant to subsection 1 is the final agency action of the department for the purposes of judicial review under Title 5, section 11001.

[ 2003, c. 649, §1 (NEW) . ]

### SECTION HISTORY

2003, c. 649, §1 (NEW) .

## §1720. NURSING FACILITY MEDICAL DIRECTOR REIMBURSEMENT

The department shall include in its calculation of reimbursement for services provided by a nursing facility an allowance for the cost of a medical director in a base year amount not to exceed \$10,000, with that amount being subject to an annual cost-of-living adjustment. [ 2005, c. 242, §1 (NEW) . ]

### SECTION HISTORY

2005, c. 242, §1 (NEW) .

## §1721. PROHIBITION ON PAYMENT FOR HEALTH CARE FACILITY MISTAKES OR PREVENTABLE ADVERSE EVENTS

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Health care facility" means a hospital or ambulatory surgical center licensed under chapter 405.

[ 2007, c. 605, §1 (NEW) . ]

B. "Mistake or preventable adverse event" means any of the following events that is within the health care facility's control to avoid:

- (1) Surgery performed on the wrong body part;
- (2) Surgery performed on the wrong patient;
- (3) The wrong surgical procedure performed on a patient;
- (4) Unintended retention of a foreign object in a patient after surgery or another procedure;
- (5) Intraoperative or immediately postoperative preventable death of a patient classified as a normal healthy patient under guidelines published by a national association of anesthesiologists;
- (6) Patient death or serious disability caused by the use of contaminated drugs, devices or biologics provided by a hospital or ambulatory surgical center;
- (7) Patient death or serious disability caused by the use or function of a device in patient care in which the device is used for functions other than as intended;
- (8) Patient death or serious disability caused by an intravascular air embolism that occurs while being cared for in a health care facility;
- (9) An infant's being discharged to the wrong person;
- (10) Patient death or serious disability caused by a patient's elopement for more than 4 hours;
- (11) Patient suicide or attempted suicide resulting in serious disability while being cared for in a health care facility;
- (12) Patient death or serious disability caused by a medication error such as an error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration;
- (13) Patient death or serious disability caused by a hemolytic reaction due to the administration of incompatible blood or blood products;
- (14) Maternal death or serious disability caused by labor or delivery in a low-risk pregnancy, labor and delivery while being cared for in a health care facility;
- (15) Patient death or serious disability caused by hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility;
- (16) Death or serious disability caused by failure to identify and treat hyperbilirubinemia in neonates prior to discharge;
- (17) Stage 3 or 4 pressure ulcers acquired after admission to a health care facility;
- (18) Patient death or serious disability due to spinal manipulative therapy;
- (19) Patient death or serious disability caused by an electric shock while being cared for in a health care facility;
- (20) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- (21) Patient death or serious disability caused by a burn incurred from any source while being cared for in a health care facility;
- (22) Patient death caused by a fall by a patient who was or should have been identified as requiring precautions due to risk of falling while being cared for in a health care facility;
- (23) Patient death or serious disability caused by the use of restraints or bedrails while being cared for in a health care facility;
- (24) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider;

- (25) Abduction of a patient of any age;
- (26) Sexual assault of a patient within a health care facility;
- (27) Death or significant injury of a patient resulting from a physical assault that occurs within a health care facility; and
- (28) Artificial insemination with the wrong donor sperm or donor egg. [ 2007, c. 605, §1 (NEW) . ]

[ 2007, c. 605, §1 (NEW) . ]

**2. Prohibition.** A health care facility is prohibited from knowingly charging a patient or the patient's insurer or the patient's employer as defined in Title 39-A, section 102, subsection 12 for health care services it provided as a result of or to correct a mistake or preventable adverse event caused by that health care facility.

[ 2009, c. 31, §1 (AMD) . ]

**3. Patient education.** A health care facility is required to inform patients of the prohibition on payment for health care facility mistakes or preventable adverse events.

#### *§1721. Voluntary restraint*

*(As enacted by PL 2007, c. 629, Pt. C, §1 is REALLOCATED TO TITLE 22, SECTION 1722)*

[ 2007, c. 605, §1 (NEW) . ]

#### SECTION HISTORY

RR 2007, c. 2, §9 (RAL). 2007, c. 605, §1 (NEW). 2007, c. 629, Pt. C, §1 (NEW). 2009, c. 31, §1 (AMD).

## **§1722. VOLUNTARY RESTRAINT**

*(REALLOCATED FROM TITLE 22, SECTION 1721)*

**1. Voluntary restraint.** To control the rate of growth of the costs of hospital services, each hospital licensed under chapter 405 may voluntarily restrain cost increases and consolidated operating margins in accordance with this section. Each hospital shall annually report to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding its efforts made pursuant to this section. The targets and methodology apply to each hospital's fiscal year beginning on or after the effective date of this section.

A. Each hospital may voluntarily hold its consolidated operating margin to no more than 3%. For purposes of this paragraph, a hospital's consolidated operating margin is calculated by dividing its consolidated operating income by its total consolidated operating revenue. [ 2007, c. 2, §9 (RAL) . ]

B. Each hospital may voluntarily restrain its increase in its expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge to no more than 110% of the forecasted increase in the hospital market basket index for the coming federal fiscal year, as published in the Federal Register, when the federal Centers for Medicare and Medicaid Services publishes the Medicare program's hospital inpatient prospective payment system rates for the coming federal fiscal year. For purposes of this paragraph, the measure of a hospital's expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge is calculated by:

- (1) Calculating the hospital's total hospital-only expenses;
- (2) Subtracting from the hospital's total hospital-only expenses the amount of the hospital's bad debt;



(3) Subtracting from the amount reached in subparagraph (2) the hospital taxes paid to the State during the hospital's fiscal year; and

(4) Dividing the amount reached in subparagraph (3) by the product of:

- (a) The number of inpatient discharges, adjusted by the all payer case mix index for the hospital; and
- (b) The ratio of total gross patient service revenue to gross inpatient service revenue.

For the purposes of this paragraph, a hospital's total hospital-only expenses include any item that is listed on the hospital's Medicare cost report as a subprovider, such as a psychiatric unit or rehabilitation unit, and does not include nonhospital cost centers shown on the hospital's Medicare cost report, such as home health agencies, nursing facilities, swing beds, skilled nursing facilities and hospital-owned physician practices. For purposes of this paragraph, a hospital's bad debt is as defined and reported in the hospital's Medicare cost report and as submitted to the Maine Health Data Organization pursuant to Title 22, chapter 1683. [ 2007, c. 2, §9 (RAL) . ]

[ 2007, c. 2, §9 (RAL) . ]

#### SECTION HISTORY

RR 2007, c. 2, §9 (RAL) .

### §1723. PROCESSING FEE

Beginning October 1, 2010, a facility or health care provider subject to the licensing, certification or registration processes of this chapter or chapter 405, 411, 412, 417 or 419 shall pay a processing fee not to exceed \$10 to the department for the reissuance of a license, certificate or registration when the licensee, certificate holder or registration holder made changes that require the reissuance of a license, certificate or registration. [ 2009, c. 590, §1 (NEW) . ]

The department may adopt rules necessary to implement this section. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [ 2009, c. 590, §1 (NEW) . ]

#### *§1723. Criminal background checks*

*(As enacted by PL 2009, c. 621, §1 is REALLOCATED TO TITLE 22, SECTION 1724)*

#### SECTION HISTORY

RR 2009, c. 2, §49 (RAL) . 2009, c. 590, §1 (NEW) . 2009, c. 621, §1 (NEW) .

### §1724. CRIMINAL BACKGROUND CHECKS

*(REALLOCATED FROM TITLE 22, SECTION 1723)*

Beginning October 1, 2010, a facility or health care provider subject to the licensing or certification processes of chapter 405, 412 or 419 shall obtain, prior to hiring an individual who will work in direct contact with a consumer, criminal history record information on that individual, including, at a minimum, criminal history record information from the Department of Public Safety, State Bureau of Identification. The facility or health care provider shall pay for the criminal background check required by this section. [ 2009, c. 2, §49 (RAL) . ]

The department may adopt rules necessary to implement this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [ 2009, c. 2, §49 (RAL) . ]

#### SECTION HISTORY

RR 2009, c. 2, §49 (RAL) .

## §1725. NEUROPSYCHOLOGICAL AND PSYCHOLOGICAL EVALUATIONS

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Neuropsychological evaluation" means a testing method through which a neuropsychologist or a psychologist can acquire data about a person's cognitive, behavioral and emotional functioning for purposes of diagnosing or confirming a diagnosis of cognitive deficit or abnormalities in the central nervous system. [2013, c. 353, §1 (NEW).]

B. "Neuropsychological or psychological test data" means raw and scaled scores, a person's responses to test questions or stimuli, a neuropsychologist's or psychologist's notes and recordings concerning the person's statements and behavior during a neuropsychological evaluation or psychological evaluation and those portions of neuropsychological or psychological test materials that include the person's responses. [2013, c. 353, §1 (NEW).]

C. "Neuropsychological or psychological test materials" means manuals, instruments, protocols, assessment devices, scoring keys, test questions and stimuli used in conducting a neuropsychological evaluation or psychological evaluation. [2013, c. 353, §1 (NEW).]

D. "Psychological evaluation" means a testing method through which a psychologist acquires data about a person's cognitive and emotional functioning for purposes of determining cognitive ability, diagnosing a mental health condition or confirming a mental health diagnosis. [2013, c. 353, §1 (NEW).]

[ 2013, c. 353, §1 (NEW) .]

**2. Disclosure of neuropsychological or psychological test materials and neuropsychological or psychological test data.** The disclosure of neuropsychological or psychological test materials and neuropsychological or psychological test data is governed by this subsection.

A. Except as provided in paragraph B, neuropsychological or psychological test materials and neuropsychological or psychological test data, the disclosure of which would compromise the objectivity or fairness of the evaluation methods or process, may not be disclosed to anyone, including the person who is the subject of the test, and are not subject to disclosure in any administrative, judicial or legislative proceeding. [2013, c. 353, §1 (NEW).]

B. A person who is the subject of a neuropsychological evaluation or psychological evaluation is entitled to have all records relating to that evaluation, including neuropsychological or psychological test materials and neuropsychological or psychological test data, disclosed to any neuropsychologist or psychologist who is qualified to evaluate the test results and who is designated by the person. A neuropsychologist or psychologist designated to receive records under this paragraph may not disclose the neuropsychological or psychological test materials and neuropsychological or psychological test data to another person. [2013, c. 353, §1 (NEW).]

[ 2013, c. 353, §1 (NEW) .]

### SECTION HISTORY

2013, c. 353, §1 (NEW).

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